MC

Combat Fatigue Versus Pseudo-Combat Fatigue in Vietnam

*CDR Robert E. Strange, MC, USN**

IT HAS BEEN established that combat psychiatric problems have been less frequent in the Vietnam Conflict than in previous wars.[4,5] Experience aboard the U. S. Navy Hospital Ship REPOSE in the combat zone during 1966, however, indicated that pathological emotional reactions continue to occur, although less often than anticipated, and that their recognition and management are still important problems for the military medical officer. Those few cases of combat fatigue which are encountered must be recognized and differentiated from other similar appearing syndromes, most numerous of which are those of personality or psychoneurotic disorders developing symptoms in response to the stress of battle. This common occurrence may well be called pseudo-combat fatigue because of its superficial similarity to the classic situational combat reaction. Recognition of differences in these syndromes is necessary for the physician in making the decisions which will most benefit the patient and his military unit.

Combat Fatigue

The syndrome of combat fatigue or combat exhaustion is a very specific diagnostic category. It may be defined as the transient pathological reaction of a basically healthy personality to severe stress of combat, and is included in the American Psychiatric Association nomenclature in the category of Gross Stress Reactions. Regarding such reactions, the *Diagnostic and Statistical Manual* of the American Psychiatric Association states: "This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress such as in combat or in civilian catastrophe. . . . In many instances this diagnosis applies to previously more or less 'normal' persons who have experienced intolerable stress."[1] Although the presenting symptom complex may vary, the following characteristics are generally present in patients with this problem: (1) past history of comparatively healthy emotional and social adjustment, (2) previously satisfactory military performance, and (3) severe and prolonged exposure to traumatic combat experience. Also, they usually have histories of marked physical exertion and fatigue, sleep deprivation, inadequate diet, and other somatic as well as emotional stress. Other authors have previously described the variable symptoms among these patients, including generalized anxiety, depression, apathy and withdrawal, conversion reactions, agitation and disorganization, and psychosomatic manifestations.[2,3] Mild symptoms are normal among combat troops, and are considered to be pathological only when they become severe enough to impair the patients's ability to perform his duties effectively or persist inappropriately when the stress of combat is no longer present. In these cases diagnosis of Combat Fatigue is indicated.

Aboard the USS REPOSE, while providing medical support for Marine operations in the I Corps area during 1966, cases of classical combat fatigue as described above were relatively uncommon. This diagnosis was established in only 15 per cent of the psychiatric patients hospitalized aboard the vessel, but it was considered nevertheless to represent a potentially significant loss of combat manpower. It is quite possible that this figure may not be representative of the actual incidence of combat fatigue among operational units, due to many variable selection factors operating in the admission of patients on the ship. Discussion with medical officers assigned to Marine units ashore, however, indicated a roughly equivalent case load during periods of heavy engagement. It is noteworthy that most of the

From the U. S. Navy Hospital Ship REPOSE.

* Assistant Chief of Neuropsychiatry, U. S. Naval Hospital, Philadelphia, Pa., 19145. Read before the Section on Military Medicine, American Medical Association, Atlantic City, N.J., June 19, 1967.

patients hospitalized for combat fatigue aboard REPOSE were young men who had been in positions of considerable responsibility, most often junior non-commissioned officers, such as corporals assigned as squad leaders, or hospital corpsmen working with combat units. Invariably their military record was excellent, their past history that of healthy social adjustment, and their combat experience lengthy and harrowing. Characteristically, they had been in the war zone for more than six months, had strong emotional investment in their units, and functioned in a leadership or other responsible role. The most common symptom complexes were those of insidiously or acutely developing generalized anxiety or depression with accompanying psychophysiologic manifestations. The following is an illustrative case of this combat fatigue syndrome and its treatment:

Case 1. This twenty year old CPL USMC was hospitalized aboard USS REPOSE after approximately two weeks of out-patient supportive treatment by his battalion surgeon because of chronic anxiety, nightmares, and persistent headaches. History revealed that he was the product of an intact, happy family with no previous indications of emotional or social problems. He attended a trade school successfully and then enlisted in the Marine Corps. For two and one-half years he had served quite satisfactorily, and during the eleven months prior to hospitalization he had been assigned to combat duty in Vietnam. His competence was such that he became a fire team leader shortly after he arrived in the field, and very soon after that he was made a squad leader. Over a number of months he led his squad through many patrols, was involved in numerous fire fights and mortar attacks, and participated in several lengthy operations in which there was prolonged engagement with the enemy. During the month preceding his admission to the sick list his unit suffered heavy casualties, which included a number of his own squad members. On one occasion he sustained superficial wounds, as several of his men were seriously injured in a grenade blast. Shortly thereafter, his unit came under heavy mortar attack, this being the fifteenth such mortaring experience for the patient. He recalled that when this occurred "things seemed hopeless"; and, although he felt he should have been active among his men, he remained in his foxhole all night because "I was just too scared and tired to get out." He was then evacuated to his local field medical unit, but was immediately returned to duty because of apparent lack of overt symptoms. For two weeks he noted increasing apprehension, startability, nightmares, insomnia, and headaches; and he was seen on several occasions by his battalion medical officer and treated with analgesics and mild ataractic medication. His symptoms continued, however, and his effectiveness in his duties deteriorated. He was consequently transferred to *Repose* for psychiatric treatment, at which time he exhibited marked anxiety, with agitation, tremulousness, and pressure of speech. He was near tears and struggling to maintain emotional control. Thought content was dominated by combat apprehension and feelings of guilt both about this apprehension and the recent loss of men under his leadership. He reported sleeplessness, terrifying dreams, anorexia, and a sense of impending death. After initial examination he was treated with chlorpromazine, 100mgs intramuscularly, and then given the same amount orally every six hours over a twenty-four hour period. He slept soundly during this time but was able to awaken for meals and self-care. The dosage of chlorpromazine was then decreased to 50mgs orally every four hours during the waking hours of the next two days, along with 75mgs in spansule form in the late evening. Initially, this was supplemented with oral barbiturates at taps, but this was soon discontinued as a normal sleep pattern was re-established. After the first twenty-four hours of heavy medication and sleep the patient was ambulatory on the ward, and his symptoms of anxiety vastly improved. His feelings of apprehension and guilt were discussed in both individual and group psychotherapy sessions, with much ventilation and abreaction, and there were support, interpretation, suggestion, and reality emphasis by the medical officer, nursing staff, and patient group. Medication was gradually decreased and then discontinued. Although he remained ambivalent about combat, there was no recurrence of anxiety symptoms, and he was returned to full duty after ten days of hospitalization. Follow-up information indicated that he served two more months under intermittent hostile fire and satisfactorily completed his tour of duty in Vietnam.

Pseudo-Combat Fatigue

The majority of psychiatric casualities in Vietnam are not the classical syndrome of combat fatigue as described above, however. These are young men with psychoneurotic or, far more commonly, personality disorders who develop overt symptoms in the environment of the war zone. Superficially their presenting symptoms may closely resemble those of the true combat fatigue patient, but their history and hospital course are quite different. At the time of their hospitalization it may be very difficult to obtain information about their current situation and history, but, when the facts

become known, they most often reveal poor past adjustment. Usually there are indications of impulsivity, poor stress tolerance, tenuous emotional control, and/or previous psychiatric contacts and symptoms. Characteristically, these patients have been in the war zone less than six months, and the degree of combat stress has been less severe. They are rarely in positions of responsibility and leadership, and feelings of guilt are uncommon in their thought content. Even if these clues are not apparent, their response to the supportive but highly directive, reality-oriented therapeutic techniques of combat psychiatry are distinctive. Because of the deep-seated nature of their problems, inadequate motivation and poor identification with their military group, these pseudo-combat fatigue patients respond poorly to treatment, although their symptoms of anxiety, despondency, or somatic complaints may seem to improve in the comparatively sheltered environment of the hospital. The crucial test is the prospect of return to duty, and at this point symptoms frequently recur, new ones appear, or the patient may for the first time frankly discuss his past emotional problems and inability to tolerate them.

Aboard USS REPOSE, 57 per cent of the psychiatric admissions were diagnosed as personality or psychoneurotic disorders, and approximately 50 per cent of these were hospitalized following exposure to battle stress, with symptoms differing little from the combat fatigue cases. At the time of hospitalization past history was frequently not obtainable and initial treatment was very similar to that of the true combat reactions. The following case is a typical example of this pseudo-combat fatigue syndrome:

Case 2. This twenty-two year old L/CPL USMC with two years of active duty and four months of service in Vietnam was hospitalized aboard *Repose* after he "froze" while under enemy fire. At the time of admission he was grossly anxious, tremulous, and agitated. His speech was in explosive bursts, interrupted by periods of preoccupied silence, and he reported only vague memory for the combat experiences of recent weeks and the incident which had precipitated his evacuation from the field. He was immediately treated with chlorpromazine in a dosage schedule similar to that of Case 1, and twenty-four hours later his symptoms had remarkably improved. He was calm and communicative, and a history could be obtained. This indicated longstanding problems with emotional and impulse control which had caused difficulties in social, family, and school relationships. He enlisted in the Marine Corps after impulsively quitting high school, and his two years of service had been marked by frequent emotional upheavals, marginal performance of duty, and a total of nine disciplinary actions for a variety of minor offenses. His initial two months of Vietnam duty had been comparatively peaceful. As his unit made more contacts with the enemy, however, over the next two months he grew increasingly apprehensive, and this became more severe after he received a minor shrapnel wound. On the night prior to hospitalization, he was involved in a brief but intense fire fight, and he "froze" in a state of tremulous dissociation. He was sedated, maintained in the field overnight, and then evacuated to the hospital ship in the morning. There his treatment program was very similar to that of Case 1, utilizing both chemotherapy and group and individual psychotherapy, and he showed early good results, with almost complete initial disappearance of anxiety symptoms. It was noted that some tremulousness and apprehension recurred, however, whenever new casualties arrived aboard, or when combat ashore was visible or audible from the ship. He then demonstrated acute exacerbation of symptoms when confronted with the prospect of possible return to duty, and he was finally evacuated from the combat zone with the diagnosis of emotionally unstable personality after ten days of hospitalization.

Comment

Although the presenting illnesses of anxiety symptoms while under enemy fire are similar in the two patients described above, the differences are noteworthy, and demonstrate the differentiating characteristics between true combat fatigue and pseudo-combat fatigue as observed aboard USS REPOSE in Vietnam. Case 1 had previously good adjustment and lengthy combat service with severe stress; also his illness involved feelings of responsibility and guilt as much as personal fear. His response to treatment was consistent, and he remained symptom-free when faced with return to duty, even though he had ambivalent feelings about this disposition. Seventy-eight per cent of the young men with this situational reaction to combat were returned to duty from the hospital ship, usually after less than fourteen days hospitalization. Case 2, although he initially appeared to have a situa-

tional syndrome of combat, demonstrated historically his poor adaptive capacity, and further indicated this in his responses to treatment and the prospect of return to the field. It is likely that he would have become a military psychiatric patient even if he had not been exposed to battle stress. This case exemplifies the most common type of psychiatric casualty in Vietnam. Approximately 50 per cent of these patients were nonetheless returned to duty after hospitalization aboard the ship, but it was in this group that some failures and rehospitalizations occurred.

The principles of combat psychiatric treatment have been well described, are now well established, and have been well validated in Vietnam.[2,3,6] They may be summarized as (1) Treatment in the combat area; (2) Adequate sedation and replenishment of physical deprivation; (3) Ventilation and supportive-directive psychotherapy; (4) Discouragement of invalidism and (5) Attempt to return to duty as rapidly as possible. Since the Korean Conflict, the only major change in the physician's armamentarium for this treatment regimen is the present availability of phenothiazine ataractic drugs, which have proved extremely successful, as used in the case histories described above. These general techniques of early treatment can be utilized with symptomatic success in almost all combat psychiatric casualties. The medical officer is then faced with the serious problem of deciding on the disposition of these patients. It is in making this decision that accurate psychiatric diagnosis is most essential, and the few cases of true combat fatigue with their good prognosis must be differentiated from those superficially similar and much more common patients with pseudo-combat fatigue, i.e. basic personality or psychoneurotic disorders. The prognosis for a successful combat adjustment in these latter cases is much more guarded. Some of them will be able to complete their combat tour with at least limited success and should be allowed to do so, although this necessitates critical evaluation and judgment by the physician. Many of them must be evacuated out of the combat area, in order to avoid recurrence of symptoms and danger to themselves and their associates. The decision of who should be returned to duty and who should be evacuated after treatment for psychiatric symptoms occurring in combat is always a difficult one which involves many factors. Experience aboard REPOSE indicated that the single most important necessity was that of accurate diagnosis and differentiation of true combat fatigue from pseudocombat fatigue syndromes in patients with underlying emotional disorders.

REFERENCES

[1] American Psychiatric Association: Diagnostic and Statistical Manual—Mental Disorders. 1952.

[2] Glass, A.: Principles of Combat Psychiatry. Milit. Med., 177:27-33, 1955.

[3] Mullin, C. S.: Combat Psychiatry in the Field. Training Bulletin, U. S. Dept. of Navy, Bureau of Medicine and Surgery, Neuropsychiatric Branch.

[4] Tiffany, W. J., Jr. and Allerton, W. S.: Army Psychiatry in the Mid-60's. Amer. J. Psychiat., 123:810-821, 1967.

[5] Tiffany, W. J., Jr.: The Mental Health of Army Troops in Vietnam. Amer. J. Psychiat., 123:1585-1586, 1967.

[6] U. S. Dept. of Army: Psychiatric Treatment in Combat Areas. TB Med. 238, 24 November, 1952.